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ABSTRACT

This document contains five papers on women and addiction all of which were originally presented at various conferences held between 1982 and 1984. "The Chemically Dependent Woman...Who is She?" gives an overview of what is currently known about basic sociological and psychological problems that affect the lives of chemically dependent women. "Treatment for Women: What Can We Do with What We Know?" combines a theoretical perspective based on the literature about alcoholic women with the author's own clinical experience in implementing and facilitating women's groups in treatment programs. "Chemically Dependent Women and Sexuality" is a review of the literature documenting the relationship between alcoholism and various aspects of women's sexuality. "Sex and Alcohol: What Do Women Tell Us?" discusses the relationship between sex and alcohol in women's lives, focusing on acquainting counselors with women's issues and on the importance of dealing with these issues in alcoholism treatment programs. "Alcohol and Family Violence" explores gender differences between the victims and perpetrators of violence in relation to alcohol consumption and dependence, offering a theoretical analysis of the differences found. (NB)

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WOMEN AND ADDICTION

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ABOUT THE COLLECTION

The five papers in this collection are transcriptions from various presentations made by Dr. Stephanie Covington in her area of expertise -- chemically dependent women.

Basing her work on the literature and on her own research, Dr. Covington discusses issues of special relevance to women alcoholics -- sexuality, abuse, and family violence. In those presentations that are aimed at professional audiences, she also emphasizes the importance for treatment of these special issues.

ABOUT THE AUTHOR

Dr. Stephanie Covington is an internationally known speaker and trainer specializing in programs on chemical dependency for professionals in health care, industry, and the general public.

Educated at Columbia University and Union Graduate School, Dr. Covington has served on the faculties of the University of Southern California, San Diego State University, and the California School of Professional Psychology. She has conducted seminars for health professionals, business groups, and community organizations.

Dr. Covington's approach to the sensitive issues of women and addiction has given participants in her many workshops an opportunity to learn new skills in dealing with personal and societal changes in the 1980s.

Dr. Covington is the Chair of the Women's Committee of the International Council on Alcoholism and Addiction and is listed in Who's Who in California. In 1983, she was cited by the California Women's Commission on Alcoholism (San Diego Chapter) for her significant contribution to alcoholic women.

Dr. Covington also maintains a private practice in La Jolla, California.

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"The Chemically Dependent Woman... Who Is She?" has been presented twice: as the 1982 Keynote Address of the 15th Annual Conference of the Southwestern School for Behavioral Health Studies in Tucson, Arizona and at the 1983 Annual Meeting of the California Women's Commission in San Diego, California.

The presentation is an overview of what is currently known about basic sociological and psychological problems that affect the lives of chemically dependent women.

The intent of the paper is to increase people's awareness of special women's issues in the treatment of alcoholism and of other types of addiction.

THE CHEMICALLY DEPENDENT WOMAN... WHO IS SHE?

Who is the chemically dependent woman? She could be your wife, your employer, your mother, your neighbor, your lover, your doctor, your daughter, and even yourself. There are no characteristics specific to this group of women, for addiction to alcohol, and other drugs, crosses all socio-economic, educational, racial, religious, and professional lines. And no woman is immune!

Traditionally, alcoholism has been viewed as a male disease. The reality is that alcoholism, and addiction to other drugs, have also played, and continue to play, a major role in the lives of women in this society. The ramifications of this fact are many.

First, let's look at the drug, alcohol. We know that in the past few decades the increase in alcohol use among women has far surpassed that of men. Over the last 25 years, the number of women drinkers in the U.S. has increased by four million, compared to two million new male drinkers in that same time period. And as more women drink, they, too, risk developing alcohol-related problems.

But how many women are actually alcoholic? Although some studies estimate that one-third of the alcoholics in the United States are women, other sources report that this is too conservative a figure, and estimate that one-half of the alcoholics are women. It is my guess that since we represent 51% of the American population, we probably represent 51% of the alcoholic population.

This culture's need to evade and deny the reality of alcoholism in women is so powerful that it even prevails among the professionals in the alcoholism field. Although there has been some improvement over the past 10 years, due mainly to the efforts of women involved in the women's health care movement, we still see

that treatment, prevention, education, and research projects are geared primarily to the male alcoholic. For example, of 385 government-funded treatment programs, only 40 have been designed for women. Many programs are coeducational, but women only make up 20% of the client population. Of the 161 recovery homes in this country, we find that 56% are for men, versus 9% for women. In any case, 91% of all the beds are occupied by men, even in the coeducational facilities.

The societal denial only begins with the alcoholic woman. I will guess that when I say "drug addict," your mental image is of a male heroin addict on the street. The fact is that most drug addicts in this country are women addicted to prescription drugs. In the United States, we have approximately 500,000 heroin addicts, including both males and females. The estimate of the number of women who are addicted to prescription drugs is about four times that number.

Two million women in this country are addicted to legally prescribed drugs. Yet, drug treatment programs are designed for men. Basically, no research has been done on women who are addicted to prescription drugs. This is undoubtedly our nation's most hidden health problem. One statistic we do know is that 77% of women alcoholics are dually addicted. This lack of recognition of the problem of alcohol and pill addiction in women has caused many to go undiagnosed and untreated. The result of our denial is prolonged pain and premature death in many women's lives.

Women's lives are different from men's lives. If we want to understand chemical dependency in women, we must first have a general understanding of women's lives -- what the client brings with her into treatment.

Despite their different backgrounds, common "messages" run through the biographies of nearly all women. For example, when a woman is pregnant, people will often guess that it is going to be a boy if the fetus kicks a lot. On the other hand, if the fetus only moves occasionally, people will often comment that it is probably going to be a girl. When a male child is born, people will often say, "Oh, he'll follow in his father's footsteps." However, comments about the girl child's birth might be, "Oh well, you can always try again," or "She's a pretty little thing." As the infant grows, the girl baby hears, "Isn't she sweet? She's such a good baby." However, the male child probably hears, "Look how strong he is, how he holds his head up." As they grow up, boys are taught to roughhouse, and to be less gentle. Girls on the other hand, are cuddled and adored... (or molested and raped!). During playtime, a girl plays indoors with her dolls, or plays in the protected backyard on a swing set. A boy is encouraged to ride his bike and explore the neighborhood, and to participate in competitive sports.

During story-reading time, the little girl hears about Lazy Mary, frightened Miss Muffet, and empty-headed Bo Peep. Or there might be Cinderella, Sleeping Beauty, and beautiful heroines who are always young and waiting to be rescued by a high-status male. But a boy hears about Jack jumping over a candlestick, and about Jack climbing the beanstalk and subduing the giant. As children get older and read to themselves, they soon find that boys are portrayed as intelligent, resourceful, and active, while girls are portrayed as passive and domestic. Mothers are shown cooking, cleaning, and caring for babies. Fathers go to work to earn money and to achieve. Girls learn to get attention by smiling and by acting coy or helpless. Girls are told they should not be selfish. Boys are taught to assert themselves, to say what they want, to fight for it if necessary. Girls

are told not to "rock the boat" and that "you catch more flies with honey than with vinegar." Those privileged young women who go to college will probably study humanities or the arts, education or nursing. Meanwhile, their young male counterparts will study science, math, and preprofessional courses. As a college graduate with honors in English, if you are a woman, potential employers will ask, "How fast can you type?"

In early adulthood women plan to get married and to "live happily ever after." As adults, women have been programmed for dependency, passivity, and triviality. We have believed what we have been told: that it is important to spend time on our hair, on our nails, and on wearing the latest fashions. Careers and money management are not issues of concern to us. We have been raised to be dependent on someone else.

When all this fails, when our dependency on someone else fails, we often turn to something else. A lot of women turn to pills and alcohol to blot out the pain of their unrealistic dreams and unrealized fantasies. Of course, it is true that women have bought those dreams and fantasies. We have <u>looked</u> for people to take care of us and, in so doing, have given up the responsibilities and the respect that come with the ability to function as an independent adult.

What does the research tell us about chemically dependent women? As mentioned before, there is very little research on women who are addicted to prescription drugs only, although we know that alcoholic women are generally dually addicted and are often polydrug abusers. It is crucial to keep abreast of the latest developments in this research, as it is important to erase myths so that we can have effective outreach and treatment programs for women.

The first area of chemical dependency that I would like to examine is the physiological factor being addressed in the research. As more and more research is completed, the findings indicate that alcoholics metabolize alcohol differently than nonalcoholics. Therefore, there are physiological differences between alcoholics and nonalcoholics. With women, we know that there is a relationship between alcohol, hormonal state, and metabolic functioning. We know that the menstrual cycle affects the way a woman reacts to drinking, and that women get drunk faster than men on equivalent amounts of alcohol, even when the weight factor is controlled. However, women on birth control pills have reactions to alcohol that resemble the reactions of men.

We also know that women alcoholics are at increased risk of having liver damage and pneumonia. Alcoholic women also experience many gynecological difficulties including sterility, repeated miscarriages, and difficulty with conceiving. Some studies have tried to relate the onset of menopause to excessive drinking in women. However, extreme care must be taken with that type of correlational research, because menopausal changes often occur simultaneously with role changes as mother and caregiver when children grow up and leave. Therefore, it may be difficult to separate evidence of physiological stress from middle-age feelings of abandonment and despair.

In the fields of psychology and sociology, the literature indicates that women entering treatment are more deviant than men. Physicians describe the women as more depressed and more emotional. What is really being observed is more deterioration in women due to their polydrug abuse. It has also been said that there is a "telescoping factor" for women -- that is, that while women start drinking later, they come into treatment earlier. I believe that, in part, this

factor is also attributable to polydrug use. In her study, Alcoholic Women in Treatment, Eileen Corrigan found that this period of buildup toward alcoholism (known as "telescoping") really was not significantly different for women or men.

Another myth that needs to be examined is the idea that women drink reactively, and that they report a particular life crisis, like separation, divorce, child leaving home, etc., as the reason for their drinking. This has only been found true in about half of the female cases. When the data is controlled for age, it appears that men and women who start drinking at the same periods of their lives experience an equal amount of reactive drinking.

There is also some discussion about women drinking alone, usually at home, as compared to men, who drink in bars. It has been found that only certain groups of women drink alone -- unmarried employed women. Some women also seem to be able to control their drinking part of the time during middle-stage alcoholism, particularly in social situations. However, when they are drinking alone, they lose that control.

Another area that needs to be questioned and explored further, from a sociological standpoint, is the research indicating that alcoholic women suffer from sex-role confusion. With our increased knowledge over the past 10 years about the way in which women are socialized, it can be seen that women's drinking has more to do with narrowness of the female role than sex-role confusion. The Broverman study helped in understanding this female dilemma. In this study, clinical therapists were asked to describe a healthy adult, a healthy male adult, and a healthy female adult. Both female and male therapists assigned similar characteristics to the healthy adult and the healthy male adult. However, they characterized the female adult as passive, dependent, emotional, easily influenced,

and noncompetitive. Therefore, this study equated "normal" and "healthy" with a stereotypic male identity. With this definition, the female is caught in the position of having to choose between unhealthy female attributes, or developing the characteristics of a healthy adult -- and being labeled masculine.

One of the more recent studies suggests that androgyny -- that is, choosing behavior appropriate to the situation, without male/female definition, offers a more human mental health standard than traditional masculine-feminine stereotypes. This study found that nonandrogynous women and men manifested significantly higher incidence of alcoholism than did their androgynous counterparts. These results support the theory that sexual conflict in alcoholic women is generated by a role too narrowly defined by society.

The two other areas often left unmentioned in discussions about treatment of chemically dependent women are the areas of abuse and sexuality. The research I completed found that alcoholic women have experienced an inordinate amount of emotional, sexual, and physical abuse in their lives, the majority of which occurred before the age of 12. The perpetrators of this abuse were usually men, and men that were known to the survivor.

We already know that alcoholic women suffer with problems of sexual function. My research showed that sexual dysfunction is a problem area for alcoholic women both during the period of their alcoholism and in sobriety. While in past studies the term "frigid" has been used in speaking of alcoholic women and their sexual dysfunction problems, the appropriate term is "preorgasmic."

When alcoholic women are studied, researchers tend to lump them into a single category -- "the alcoholic woman." This suggests that the nature of the illness and the treatment needs of all alcoholic women are the same. Just as the

assumption that women alcoholics are identical to men has been questioned, I think that the assumption that all alcoholic women are similar must also be challenged. For example, minority women, i.e. Hispanic, black, native American, etc., have special needs that must be addressed. We must look at the needs of the older woman, the handicapped woman, and the lesbian alcoholic. The findings so far indicate that within such minority populations where oppression and alienation are common, alcohol use is far greater than in the general population.

To this point, I've been focusing on the alcoholic woman. However, what about the woman who abuses prescription pills? We really do not know much about her from physiological, sociological, or psychological studies. However, we do have some information about the system in which this woman lives. We also know something about the roles that the media, the pharmaceutical industry, and the health care professionals play in this problem, and how they help to perpetuate it.

Women are addicted to prescription drugs far more often than men. One of the reasons for this is that women receive twice as many drugs as men do for the same symptoms. We also know that over three quarters of all prescriptions for mood-altering drugs are written for women. Studies have shown that most doctors believe that their "typical" complaining patient is a woman. Management companies that help doctors set up their practices allow approximately 7 minutes per patient visit. If a patient comes in complaining of a variety of symptoms, i.e. headaches, backaches, insomnia, and depression, that person is going to be given a prescription because the doctor cannot determine a specific diagnosis in 7 minutes. However, according to one study, doctors who saw male patients and female patients with exactly the same symptoms prescribed drugs for the women, and medical tests for the men.

When we look at the role of the advertising media, it appears that drug advertising is aimed at turning normal problems of living into medical problems. This is particularly true of women's problems. For example, women go to doctors for normal life processes such as menstruation, childbirth, and menopause. Therefore, women see their doctors more often than men, and their normal life processes are often treated as diseases. The ads placed by the drug industry in medical journals portray women as depressed, anxious, and unable to cope. Events such as a child going off to college or loss of a loved one are shown as requiring medication to deal with the emotions that these life situations evoke. On daytime television, it is clear that over-the-counter prescription ads are geared toward women.

The relationship between the medical profession and the pharmaceutical industry is very incestuous. Doctors receive information on specific drugs from the industry producing the products. Not only do drug company representatives call on physicians three to five times a week to push their products, but the pharmaceutical industry also pays for such things as continuing education courses, television sets and trips, and uses a whole array of methods to sway physicians toward prescribing their medications. The majority of the information and education a physician receives about drugs comes from sales representatives, not from work in medical school.

The major prescribers of mood-altering drugs are internists and gynecologists, not psychiatrists, who do have some knowledge of these drugs. Even the PDR (Physicians Desk Reference), which is considered the "doctor's bible," is published by the pharmaceutical industry. The drug companies spend much more on advertising every year than they do on research. Advertising information

indicates that the drug industry spends about $7,500 annually per physician on direct advertising. Other facts show that the U.S. drug industry has ranked first or second in profitability among U.S. industries consistently over the past 25 years, and Valium continues to be the most prescribed drug in America.

Statistics show that accidental addiction to legally prescribed drugs is a hazard threatening one out of every four American women. Because unsuspecting women take pain killers, tranquilizers, diet pills, and sedatives -- often using them in combination with alcohol -- they are susceptible to accidental addiction and death. While it has never been socially acceptable for women to take drugs, it has always been permissible for women to take medicine. Remember, however, that initially, when these drugs were originally put on the market, we were told that they were nonaddicting.

Now that we have established the fact that women do turn to pills for relief, it should be useful to explore some of the reasons. One reason that women use pills is to alleviate stress. Everyone experiences stress. As women, our changing role in society is stress-producing. Also, it appears that women are relatively comfortable expressing their feelings. Thus, we are more likely to report symptoms of an emotional origin. However, such expressions are often viewed by doctors as signs of weakness -- and it only takes 30 seconds to prescribe a pill. Women also go to doctors more often than men. We go to doctors even when we are healthy, and the majority of our visits result in a prescription. We also know that we take a very passive role in regard to health care, often looking upon the doctor as a God-like figure, and not taking responsibility for maintaining our own health or asking sufficient questions. It is well-documented that most physicians are men, and that they are largely sexist in their prescribing practices. We also know that the pharmaceutical industry is a highly profitable one.

We need to be aware of these environmental influences as we look at women who abuse prescription drugs. Women are finding it necessary to resist the entire traditional medical system, which is made up of very large institutions and deeply rooted traditions in our society. We are living in a society that loudly proclaims "relief is just a swallow away." In our culture, drugs have become an acceptable way to deal with internal pain, boredom, and anxiety, as long as we can continue to function adequately in the eyes of the outside world. So we take psychoactive medicines designed to speed us up or to slow us down, at will.

However, let us be aware of the realities of chemical dependency and its effect on women -- erase the myths, understand the problems, and look for answers, so that we may be able to bring effective outreach and treatment to the deliberate and accidental victims of this destructive system.

Next I would like to address some of the clinical issues that women bring into treatment, characteristic of women who are either alcoholics or polydrug abusers. There is a tremendous amount of depression among these individuals. When they are sad or unhappy, they feel life is not worth living; they become suicidal. They view themselves as hopeless and helpless, feeling like "victims" of life. They lack self-confidence, yet most of them are striving for "perfection." They have difficulty expressing a positive range of emotions.

Anger is one of the emotions to which these women seem to react to extremes; either they do not express it at all, or they become explosive. Most women have never learned to deal with anger. We have viewed ourselves as impaired, second-class citizens, and there is some reality in that perception. Women tend to be passive, yielding to the needs of others, believing that their feelings do not count. They often feel "phony" and do not have a clear self-

identity. Life often seems pointless to them, even in sobriety. They often feel that nobody needs them.

These are some of the clinical issues I have seen that need to be dealt with. Often, additional problems exist in the area of interpersonal relationships. Problems in relationships with others are often due to the isolation of these women. Their social skills are weak, so they need to learn how to relate to others. Relationships they develop through Alcoholics Anonymous help them in the resocialization process.

Intimate relationships are another problem area. Sexuality is a real issue, because often initial heavy drinking was related to early sexual experiences. The majority of these women have not been sexual without the use of alcohol.

I would like to tell you about a woman named Susan that I met a few years ago at an AA (Alcoholics Anonymous) meeting. I had sat down beside her and had introduced myself. We talked for a while; it was one of the first AA meetings she had attended. I went out of town. After I returned, I discovered that she had tried to commit suicide, so I called her, and we began to attend AA meetings together. The main focus of her conversations with me, and the two main concerns of her life, were her husband and having a baby. She did not want to lose her husband, and she wanted to be pregnant. She was not sure whether or not she was alcoholic, but she could never stay away from liquor for more than three days at a time. A month went by and she decided that AA was not for her. She started seeing a psychiatrist, and when I checked in with her she indicated that the doctor was helping her. Her husband had asked that she only drink beer or wine now and then, no hard liquor.

I did not hear from her again. One day, as I sat writing a speech, she came to my mind. I was at that part in the speech where I was describing the alcoholic woman: her low self-esteem, the shame and the guilt. I remembered Susan. By all external evidence, she seemed to have everything that our society says that a woman should want. She was young. She was attractive. She had beautiful clothes, and she was married to a highly skilled professional man. She had a job, and she was financially contributing to the marriage. She was a professional woman with an education. I continued to work on my presentation, then I decided to give her a call to see how she was doing. I wanted to see how she was handling her "controlled drinking." The telephone rang several times. Finally a sleepy male voice said, "Hello." I was told that she was not in, so I explained that I wanted to leave a message. Because he was so sleepy, I really had to encourage him to get a pencil and paper. When he came back to the phone he said, "Oh, I know. You're looking for Susan," as though he had not heard me the first time. I said, "Yes." He said, "She's not here anymore." "Oh," I said, "has she moved?" I remembered that she had mentioned something about moving to another town. He said, "No, she is deceased." "Deceased," I repeated. "How did she die?" He said he did not know. Then I said to him, "It was pills. She committed suicide with pills." He said, "Yes," and I hung up. As the tears started to roll down my face, I realized that here was one that had slipped through the cracks. I experienced all kinds of feelings in those first moments. First, I was very angry. Her husband did not want her to stop drinking. The psychiatrist kept seeing her and giving her pills. All she could think about was her husband, and having a baby. After the anger subsided for a moment, my guilt came up. Why hadn't I done more? Why hadn't I continued to

call her? Then all the "if only's" began: If only . . . if only . . . I think it was in that moment that I fully realized what it is to be powerless over alcohol. For not only am I powerless over the alcohol that I drink, but I am also powerless over the alcohol that others drink.

Susan's story tells us a lot about the effect of alcohol on women's lives. Perhaps it tells us more than the statistics do. The numbers say that half of the alcoholics in this country are women. However, only 20% of the people in alcoholic treatment programs are women. Why is that? It is because of the stigma. Women stay hidden because we have been told that it is not okay. The epitome of female adulthood is to be a "lady," and you cannot be a lady when you are drunk. Women who are alcoholic have overstepped the boundaries that society has prescribed for them. They are not fulfilling the role of "a lady." Because of our shame and the guilt around that, we stay hidden. If we stay hidden long enough, we die.

Yes, alcoholism is a disease, and the characteristics are the same for both males and females. However, there are many special aspects for women. Their denial is greater because of the stigma. This denial keeps women from needed treatment. There is also the denial of their "problem" by family and friends, which compounds the problem. Friends and family are often afraid and ashamed when they love a woman who has this disease. When a woman who is suffering from pain goes to the doctor, the general response to the symptoms she reports is yet another drug prescription. So she may end up dependent on the second drug as well. Women in the workplace are also often hidden and not in the employee assistance programs. One reason they are not referred for treatment is that, often, they are replaceable. Another factor is that most women are overskilled

for the jobs that they hold. Therefore, it maybe possible for them to maintain their performance while being addicted.

When I think back to Susan, what hits me the hardest is her feelings about herself: her shame, guilt, and self-hatred. This is how the double standard keeps a woman alcoholic invisible. She internalizes the culture's harsh judgment of her and learns to view herself with hopelessness and hatred. Studies repeatedly show that alcoholic women suffer more guilt, anxiety, and depression than alcoholic men. They have lower self-esteem and they attempt suicide more often. This sense of self-disgust pushes a woman deeper into alcoholism. Such was the case with Susan. She had no sense of self. Without a sense of self, we have an emptiness inside. Many of us continue to use alcohol and other drugs to try to fill us up, and to keep our focus off ourselves.

As women, traditionally we have defined ourselves in terms of things outside ourselves. How many women do you know who, when you ask them about themselves, tell you about their kids or their husbands? In recent years, such women may even tell you something about their jobs. However, very often a woman can think of nothing to tell you other than these things, because this is her sense of identity. She has identified herself by things outside of herself. In the case of Susan, her identity was made up of external factors only: her husband, her clothes, her physical appearance, and her job. But who was she?

That, I think, is the challenge in sobriety: to learn to be able to see our lives, and to find ourselves. For many of us, the removal of alcohol and other drugs from our lives is merely the first step in a very, very big process. Only then can we begin to look at ourselves and our other dependencies, -- all of those things we are afraid not to have in our lives, the things we use to fill ourselves up.

As women, we have been brought up to be dependent. Think about the young adult years of a woman's life. We are supposed to be dependent on someone else to ask us for a date, to open the door, to ask us to dance, and to ask us to get married. After marriage, we are supposed to be economically dependent. If you stay at home alone with the children, you become emotionally dependent on someone who, hopefully, comes home at night. This is what society tells us is the woman's role: to be dependent. As long as we are dependent, we are no longer free to make choices, because being dependent on something outside ourselves means we give up our freedom of choice. We give up our personal power.

So, we can see that the problems of alcoholism and addiction to other drugs are not limited to the male experience. Chemical dependency plays an important role in women's lives, too. I do not believe that a woman can get through life in this society without being affected. A woman's first experience with alcohol may be because she has been brought up in an alcoholic family. Because of that experience, she runs a very great risk of having been physically or sexually abused. Alcohol use is associated with 60% of the child abuse cases, and 60% to 70% of the father-daughter incest cases. The roles she had to play in an alcoholic family in order to survive are often repeated in adulthood where her interpersonal relationships may be handicapped by the earlier experiences.

A woman is also affected by alcoholism when she is in a relationship with an alcoholic. She is not only in a relationship with somebody who is not available to her, but she is also in a situation where she may be battered. Sixty-five percent of domestic violence involves alcohol. In these cases, she is in a real cultural bind. She has been raised to be the nurturer. She has been raised to be the caretaker. She has been taught by society to be the good wife. In this case, the

things that she has been brought up to do actually enable her partner to drink, so she is trapped.

We have already covered the third and, I think, most devastating way in which alcoholism affects a woman: when she herself is an alcoholic. Here she loses her total sense of self.

As we look at this picture of alcoholism and drug abuse in women's lives, I feel we have a responsibility. That responsibility is to put out a hand to our sisters -- to that woman out there who is struggling, to the Susans of the world. Some women need more than one hand. True, Susan dropped through the cracks, but there are others like her. I think we, as health care professionals and as caring human beings, need to reach out to women, and to give them support and love to help them find their way. We need to assist them into sobriety, into becoming fully actualized human beings. That is what sobriety is all about. Sobriety means expressing our full potential and enjoying the richness of life.

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"Treatment for Women: What Can We Do with what We Know?" was first presented in 1982 at the National Alcoholism Forum in Washington, D.C. Later that year it also became one of the presentations made at the 33rd International Congress on Alcoholism and Drug Dependence in Morocco. It was also presented in 1984 at the 30th International Institute on the Prevention & Treatment of Alcoholism in Athens, Greece. This paper combines a theoretical perspective based on the literature about alcoholic women and Dr. Covington's own clinical experience in implementing and facilitating women's groups in treatment programs.

TREATMENT FOR WOMEN:
WHAT CAN WE DO WITH WHAT WE KNOW?

Traditionally, alcoholism has been seen as a "man's disease." Yet the reality is that alcoholism has played and continues to play a major role in the lives of women in this society. In the past few decades, the rate of increase in alcohol use among women in the U.S. has far surpassed that of men. In the past 25 years, the number of women drinkers has increased by four million -- compared to two million new male drinkers. As more women drink, more women risk developing alcohol problems. The 1974 Gallup poll shows that 10% of women who use alcohol say they sometimes drink more than they should. But how many women are actually alcoholic? Some recent studies estimate one-third of the ten million alcoholic people in the United States are women. Other sources indicate that this figure is too conservative and estimate that one-half the alcoholics are women. Since women represent 51% of the population in the United States, I believe that women probably also represent 51% of the alcoholics. We do know that the past 10 years have shown a dramatic rise in the number of new members of Alcoholics Anonymous who are female.

Our culture's need to evade and deny the reality of alcoholic women is so powerful that it permeates the alcoholism field itself. Historically, women have been virtually ignored in the field of alcoholism. Treatment, prevention, education, and research projects have been geared primarily to the male alcoholic. Although the past decade has produced an abundance of research on alcoholism, studies focusing on alcoholism in women are still scant. The studies tend either to ignore women entirely or simply to assume that alcoholism is the same, regardless of the sex of the sufferer. This lack of information constitutes a serious blind

spot in the field of alcoholism. Although the research is sparse, it is important that we in the field become aware of the nature of alcoholism in women. One important aspect that both professionals and lay people need to understand is the double standard and stigma the alcoholic woman faces. How society sees the alcoholic woman is pertinent to treatment.

Most of us can't bear to deal with women who have drinking problems. We see an image cracking -- so we keep the alcoholic woman invisible. And the woman herself, sensing the unacceptability of her illness, does not protest. Fortunately with the many social, political, and economic changes in our society, women's role has begun to change. It has only been recently that we have begun to realize that alcoholism is a women's disease as well, and the realization has been growing rapidly that it is time to take a look at the special needs and concerns of the alcoholic woman. While the characteristics of the disease of alcoholism -- low self-esteem, obsession, rigidity, loss of control, compulsion, negativity, physical complaints, etc. -- are the same for men and women, they are often more pronounced in the female alcoholic. Treatment programs for women can no longer be just an extention of a male program.

Alcoholism is different for women because our lives are different. The best analogy I know is breast cancer. Both men and women can have breast cancer. But the ramifications and implications of the disease for a woman are far greater than for a man. It touches and affects her view of herself as a woman -- her identity. This is also true of alcoholism. When a woman is an alcoholic, the very core of her being is affected. When a man is drunk, he is often excused as "being one of the boys." This is not true for a woman who is drunk. We have been socialized to believe the epitome of female adulthood is to be a lady -- and

it's very difficult to be a lady when you're drunk. The realities of women's lives also create special circumstances and problems, which the female client brings to her alcoholism treatment.

Besides the increased stigma, isolation, depression, alienation, and low self-esteem, the woman alcoholic frequently lacks family support, has an underskilled or undertrained work history, and is responsible for children. These are additional barriers to treatment.

Women also run particular risks with this disease. They seem to suffer from health-associated problems much earlier, i.e., the disease progresses faster, the average death age is lower than for males. Women risk having babies with Fetal Alcohol Syndrome. Their alcoholism goes undetected longer because of society's inability to conceive of an alcoholic woman who is not a "tramp." They are also more apt to be dually addicted because they see the doctor more often; normal processes in a woman's life, like menstruation, childbirth, and menopause are often treated as illnesses.

Therefore, treatment programs for women optimally should provide services dealing with these problems and circumstances by offering child care services, family and legal counseling, vocational guidance and skills training, and a complement of services dealing with the social oppression of women in helping to provide her with increased self-esteem, self-reliance, and a chance for self-actualization. In addition to alcoholism counseling, how can we provide these services much needed by women? There are two avenues we need to follow: (1) treatment programming, and (2) advocacy and networking. The treatment model I'd like to share with you is one that can be easily adapted and implemented into an existing program structure, an important consideration in this time of fiscal uncertainty and scarcity.

Women need to be in groups with other women where they can feel safe, where they can share their experiences, their pain, and their secrets. This is a place where what a woman says is her truth, because it is her experience and her reality. Women need to be in groups that are not set up for confrontation. Women are up against the wall everywhere in their daily lives. This kind of group is designed to help them feel secure knowing that they will not be challenged, argued with, made to explain and justify themselves.

The basis for women's groups is validated by several research studies. One is a study done by Aries on small-group interaction patterns. It was found that when women were put in groups, the discussion focused on feelings and emotions and personal experiences. And in an eight-week period, the leadership role shifted among the group members. When men were put in groups, the leader emerged within the first two sessions and remained the dominant person throughout the eight-week period. In the men's group, discussion centered on activities and competition and skills. When men and women were mixed in a small group, the men became the leaders and dominated the sessions. Content also changed. The discussion became less competitive and less activity and skill related, and there was more discussion of feelings by the men. The women discussed their feelings less. Basically, the women became facilitators for the men. The mixed groups were beneficial for men, but they were not beneficial for women. So when you are in your treatment program and put people in mixed groups, you are helping the male alcoholic and you are doing a detrimental service to the female. The Broverman study pointed out that, as treatment providers, we very often look at men and women differently. In this study, therapists and counselors were asked to describe a healthy adult, a healthy female, a healthy male. The description

for a healthy male and for a healthy adult were identical. But the healthy female was very different from the description of a healthy adult. Unlike the male, the respondents characterized the female adult as passive, dependent, emotional, easily influenced, and noncompetitive. This study points out the bias of mental health professionals. Normal and healthy was equated with a stereotypic male, leaving the female in the dilemma of choosing unhealthy female roles or developing in the direction of a healthy adult and being labeled masculine. The third study, done by Schultz, reported the results of a feminist treatment approach in a drug agency. When a women's group was facilitated by a woman and focused on women's lives and their experiences in society, the attendance increased and the recovery rate was greater. When the group was facilitated by a male, the attendance dropped off, and the recovery rate was smaller. So, based on the findings of those three studies let's talk about how you set up a group.

The following are guidelines:

1. Eight to ten people sit in a circle. See the list that follows these guidelines for possible topics of discussion. The group should meet for a minimum of 1½ hours.

2. The facilitator is a woman. Her role is to keep the discussion focused on the topic and to remind each woman to take her turn. The facilitator participates as a group member -- sharing her own life experience.

3. This group is not for confrontation. What a woman says is her truth, and the women in the group accept her position without argument.

4. Set a few rules to make the group safe for each member:

   a. Share time equally. Each member takes her turn speaking. This should be flexible so that if a woman has a great deal to say, she could be able to do so, but she also needs to be aware of the need for other women to speak. Therefore, the group should have some idea as to how much time is available to each member.

   b. Confidentiality is a must! No personal information about any group member should be discussed outside the group. Trust is essential to a group. There can be no trust if information about a group member is given to outsiders.

c. Listen to each person attentively without interrupting. Each woman has an important experience to relate that should not be judged or challenged. Feelings are valid, no one should be told how to feel.

d. Speak about your personal experiences, not in generalizations or abstractions. This increases the feelings of closeness and women learn from each other's personal experiences.

e. Strive for complete honesty. This need not be in conflict with protecting the feelings of others.

f. Avoid side remarks to a person sitting close to you. Share all remarks with the group. Comments, questions, opinions are of interest to all members.

5. After everyone has spoken, there is a period when the group discusses the common elements in all the experiences. What are the common problems? This helps to alleviate feelings of isolation. Brainstorming should occur in order to generate ideas about how to change. Ideas should include social as well as personal change. Explore what keeps each from making personal changes -- and what kinds of support is needed. Explore what the group can do.

Some of the topics that can be included in a women's group are:

1. Who am I?
   How we define ourselves
   What it means to be a woman in our society
   What it means to be an alcoholic woman... the stigma

2. Self-esteem... what's it based on?
   Liking yourself
   Guilt

3. Mother/daughter relationships
   We are all daughters... who trained us? How have our lives been impacted?

4. Relationships
   Who comes first?
   Support, expectations, intimacy
   Asserting our own needs

5. Assertiveness
   Assertion versus aggression
   Learning to be assertive

6. Dependence/independence
   Economics
   Emotional aspects
   Interdependence... freedom to make choices

7. Health and nutrition
   How alcohol affects our health
   Developing good nutrition... let's not just change addictions
   Self-image and health

8. Stress
   What is stress?
   Evaluating stress in one's life... drinking to cope
   Stress management

9. Aging
   Do you worry about getting older? Is there a crisis age for you?
   How ads portray older women

10. Anger
    What do you do with anger? How have you been taught to express it?
    Anger turned inward = depression
    Violence: rape, incest, battering... psychological effects

11. Sexuality
    Where did you get your sex education?
    Dispelling myths... information about female sexuality
    Attitudes... guilt

12. Spirituality
    Spirituality versus religion
    Love and touch
    Visualizations, actualizations

As treatment providers, it is important for us to remember that women are not all alike. While there are similarities in all our lives, there are also differences. The struggle against alcoholism becomes more complicated for the minority woman. For the black, Chicana, physically challenged, and lesbian woman (to name a few), feelings of alienation, isolation, and low self-esteem are compounded by her minority status in our society. This is the reality of her life... this is a treatment issue.

For many women this will be their first positive experience with a group of other women. The phrases you hear... "I dislike women," and "I feel more comfortable with men"... are an extension of how society devalues women. Many women have assimilated society's negation of their gender and have come to dislike

and even to hate themselves as women. Women cannot learn to value themselves as long as they devalue other women. In order for alcoholic women to form positive feelings about themselves, they must also form positive feelings about other women. Since most of the abuse experienced by women has been perpetrated by men, women need to be with other women in order to learn to trust again and to begin to experience intimacy.

I suggested earlier that there are two paths we need to follow in order to meet women's needs. In addition to providing proper and adequate treatment by establishing women's groups, we must network and advocate for women. In today's world of monetary cutbacks we can provide additional services for women by networking and building a resource bank. It is important that we find and establish ties with other agencies that can provide the ancillary services of child care, legal advice, job training, and medical care that women need. In our own agencies, we need to advocate for women. This is hard to do alone. Find an ally and equip yourself with data to substantiate the validity of your requests (for example, the studies mentioned here about women's groups). Advocacy also means encouraging employment of women on the staff, in all capacities. Positive role modeling is an important part of treatment for the woman alcoholic.

The goal of treatment is recovery -- sobriety -- and this means much more than not drinking. In order for a woman to have good sobriety, we must assist her in becoming a fully actualized person. The women's group is the treatment modality that provides the atmosphere and opportunity for recovery and personal growth. Women sharing their feelings and experiences in a safe environment is a very healing and therapeutic process. Bringing women together breaks their isolation and alienation; it results in higher self-esteem, resocialization, bonding,

role modeling, and trust building. For the woman alcoholic, sobriety means experiencing joy in living and experiencing herself as a whole and healthy and totally functioning woman. It means feeling good about being a woman!

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"Chemically Dependent Women and Sexuality" is a review of the literature -- including the author's own research -- that documents the relationship between alcoholism and various aspects of women's sexuality.

The paper was presented at the 6th World Congress of Sexology in 1983 in Washington, D.C.

CHEMICALLY DEPENDENT WOMEN AND SEXUALITY

Largely due to the impact of the women's movement, much of what, in the past, had been presented as fact about human sexual function, has been rejected in the last 10 years. Until recently, relatively little information was available on female sexuality, and very little research had been done by women for women. Men have dominated the field of sexuality and have represented both sexes. Therefore, women have been told how they "should" behave, how they "should" feel, and what they "should" expect to feel. Women have had little opportunity to explore their own sexuality independently and to discover themselves.

The omissions and discrepancies in the research on women and alcoholism are even more apparent when the topic of sexuality is investigated. As Carpenter and Armenti (1972) noted:

> A question of considerable interest ought to be the effect of alcohol on female sexual behavior. Most experts comment on human sexual behavior and alcohol as though only males drink and have sexual interests. (p. 509)

There are several important reasons for examining the relationship between alcohol and sexuality:

1. Many people have misconceptions about the effects of alcohol on sexuality -- that alcohol is an aphrodisiac.

2. Heavy drinking and alcoholism may be directly related to sexual dysfunction, i.e., erectile dysfunction, lack of sexual arousal, and orgasmic dysfunction.

3. Two major problems in recovery from alcoholism are family relationships and difficulties in sexual functioning.

4. The availability of joint training in alcoholism and sexuality is practically nonexistent, so sexual dysfunction is generally not treated in recovery programs (Whitfield, Redmond, and Quinn, 1979).

SEXUAL RESPONSE

The belief that alcohol is an aphrodisiac has existed throughout history (Sandmaier, 1980). In reality, it is not. However, alcohol has long been associated with sexual behavior. The disinhibition hypothesis is the prevailing view of how alcohol enhances sexual activity. The theory is that alcohol, as a central nervous system depressant, progressively depresses higher brain functions that control or inhibit sexual behavior. According to Kaplan (1974), alcohol depresses the brain centers governing fear, thus reducing anxiety.

Some of the data (Athanasiou, Shaver, and Tavris, 1970; Beckman, 1979) suggest that a substantial proportion of women, with and without alcohol problems, view alcohol as an aphrodisiac, and they report experiencing increased sexual enjoyment when drinking. These "subjective" data are in sharp contrast to the limited "objective" physiological data available pertaining to the effects of alcohol on women's sexual responsiveness.

Wilson and Lawson (1976) found that as women subjects ingested alcohol, from the first drink their physiological arousal decreased, as measured by the vaginal photoplethysmograph. Paradoxically, the subjects reported an increase in feelings of sexual arousal, independent of whether or not they believed they had consumed alcohol. In contrast, men experienced increased physiological arousal at low blood alcohol levels, and only when they believed they had consumed alcohol. At higher blood alcohol levels, men showed the same reactions as women, i.e., decreased sexual arousal.

Malatesta, Pollack, and Crotty (1979) reported a similar study of alcohol effects on women's orgasmic response. Increasing levels of intoxication were associated with increased latency to orgasm (increased reported difficulty of attaining orgasm), and decreased reported intensity of orgasm. However, as in the Wilson and Lawson study, increasing levels of intoxication were associated with increased subjective sexual arousal and reported pleasurability of orgasm.

The data suggest a social learning explanation of how drinking affects sexual behavior, and it fails to support a simple disinhibition theory of drinking. In terms of sexual activity, a woman may become more active after drinking not only because her inhibitions have been "dissolved." She also has learned to associate drinking with sex, has come to expect that drinking will enhance enjoyment, and her drinking may be frequently done in a setting where sex partners are more readily available.

Further, in terms of sexual responsiveness, the literature seems consistent in illustrating that physiological measurements do not tell the whole story. In fact, due to psychological factors, a woman's experience of arousal may be totally the opposite of her measured physiological arousal response. This paradox highlights the complex interplay among the individual's physiological response, one's disinhibition experience with alcohol ingestion, and one's beliefs about the effects of alcohol. Because women have no visible means of "seeing" their own sexual arousal, as men do, they are dependent on subjective clues to recognize their own arousal.

SEXUAL DYSFUNCTION

Since the data in the preceding section suggest that acute intoxication lowers physiological sexual arousal in women, one could expect chronic drinking to be

accompanied by severe disturbances in sexual functioning. However, limited data are available on the prevalence of various types of sexual dysfunction in alcoholic women. And most of these data come from small clinical studies that are not clear concerning participant histories of sexual difficulties, that is, what preceded and what was a consequence of drinking.

Sexual dysfunction is often presumed to be primarily a consequence of alcohol abuse. In a recent review of clinical studies of alcoholism and sexual dysfunction, Whitfield et al. (1979) suggested six physiological mechanisms by which alcohol abuse may affect sexual functioning. These include acute depressant effects of alcohol on physiological sexual arousal, disruption of sex hormone metabolism as a result of liver damage, interference with sensory pathways of sexual arousal by alcohol-induced neuropathy, organic brain damage resulting in decreased interpersonal and sexual interest, and various medical problems secondary to alcoholism that negatively affect sexual functioning, i.e., diabetes, hypertension, urinary tract infections, and vaginitis.

In addition to these physiological mechanisms, intra- and interpersonal aspects of alcoholism may interfere with sexual functioning. Williams (1976) found that the most common sexual problem among alcoholics is the inability to form satisfying intimate relationships. This difficulty may result from the isolation, depression, and low self-esteem that characterize many alcoholic persons. These characteristics are more pronounced in women alcoholics due, in part, to the greater social stigma attached to their condition. Traditionally, women have themselves expected to have sex within the context of intimate relationships. Men have had more permission to engage in "casual sex." Therefore, the consequences of having difficulty with intimacy may play greater havoc in the lives of female alcoholics compared to male alcoholics.

It is also possible that, for some people, sexual difficulties precede and contribute to the development of their problem drinking. A number of recent studies (Curlee, 1969); Dahlgren, 1979; Sclare, 1970; Tamerin, 1978) have found that women alcoholics report marital problems, often including sexual difficulties, as possible precipitants of their problem drinking. Sexual dysfunction may be one source of life stress that contributes to drinking. In many cases, it is probable that sexual dysfunction is both cause and consequence of excessive drinking. Many people use alcohol to "treat" or cope with sexual dissatisfactions, causing a spiral effect that makes the sexual problems worse.

Data on sexual dysfunction among problem drinking women often suffer from a variety of methodological limitations. Studies have lacked clear-cut definitions of alcoholism and of sexual dysfunction, in addition to not using comparison groups. The terminology used by the authors often reflects moral judgments and sexual stereotypes. For example, the terms "frigidity" and "promiscuity" are used to describe the sexuality of alcoholic women.

Few of the available studies contain information that permits some estimation of the prevalence of sexual dysfunction. Several of the studies preceded Masters and Johnson's (1966) and Hite's (1976) landmark works on female sexuality. Also, in these studies the term "frigidity" was used to mean a woman's incapacity to achieve vaginal orgasm through intercourse. Masters and Johnson were able to demonstrate that most orgasms are in fact clitoral in origin. The Hite (1976) report suggested that only 30% of the women sampled from the general population could achieve orgasm through penile-vaginal penetration. Considering the contrasting information now available in these more extensive and more recent studies, it is difficult to assess the true nature of women's dysfunction from the older studies.

General sexual dysfunction, formerly called "frigidity," is characterized by a lack of erotic feelings or interest (Kaplan, 1974). There is an impairment in the vasocongestive component of sexual response which activates vaginal lubrication and expansion. Kinsey (1966) found that 72% of alcoholic women had a history of "frigidity," and he cited this as a factor contributing to their alcohol problems.

Orgasmic dysfunction is characterized by the inability to have an orgasm. Sholty (1979) found that 67% of alcoholic women in that study indicated that their orgasmic experience deteriorated after their drinking became a problem. Forty-seven percent of the women became anorgasmic.

Within the two comparison groups studied by Beckman (1979) and Pinhas (1978), it was found that alcoholic women reported higher levels of generalized sexual dissatisfaction than did their matched nonalcoholic controls. However, in neither study were sexual difficulties and drinking problems time-ordered for clarification of which came first.

In conclusion, the rates of sexual inhibition, reduced sexual responsiveness, and orgasmic dysfunction range from 28% to 100% in research studies on alcoholic women. Further, nowhere do the data support a stereotype of alcoholic women having loose sexual morals and being sexually promiscuous (Schuckit, 1972).

ABUSE

Physical and sexual abuse are considered common experiences among alcoholic women, although empirical data are not readily available to confirm this.

One research team (Herman and Hirschman, 1977) has noted the higher incidence of alcoholism among incest victims and their biological families. Surveys from Minnesota treatment centers have reported that 40% to 50% of their women clients are incest victims (Evans and Schaefer, 1980). These figures corroborate

a study (Benward and Denson-Gerber, 1975) that revealed a 44% rate of incest in a survey of 188 female patients being treated for chemical dependency.

It has been reported (Hammond, Jorgenson, and Ridgeway, 1979) that alcoholic women experience rape at a rate four times that of the general population (40% versus 10%). Hammond et al. also reported a definite correlation between rape and later sexual dysfunction.

Domestic violence is often attributed to alcohol use. However, studies on this subject have been contradictory, and/or they have not addressed the alcohol question in depth. Morgan (1980) cited studies which indicate that from 6% to 50% of the incidents of marital violence involve the use of alcohol.

There are no known statistics on emotional abuse, although it is expected that alcoholic women also experience this type of abuse as a consequence of living in abusive environments.

So far we have explored the relationship between alcoholism in women and sexuality. What follows is data from my own research.

The subjects in this study were 35 recovering alcoholic women who were paired with 35 nonalcoholic women (70 total). Alcoholic women with 3 to 12 months of sobriety volunteered from a variety of treatment settings, and were paired on age, education, marital status, and religious background to nonalcoholic women, who volunteered as subjects from the general community. With all subjects I used an anonymous and confidential questionnaire consisting of questions on demographics, sex history, sexual experience, and abuse. The comparison group also received the Mortimer-Filkins test to screen out possible alcoholic volunteers. After finishing their questionnaires, all subjects participated in a group discussion. This provided participants some closure to the process.

The findings indicated that alcoholic women have experienced a greater variety of sexual activities, as compared with nonalcoholic women, have engaged in a higher frequency of masturbation, and have used alcohol more often with sexual experiences. Although alcoholic women believed that alcohol contributes to good sexual experience, they appeared less responsive (orgasmic) and less satisfied with sexual responses and relationships than their nonalcoholic counterparts. The data also showed that the alcoholic subjects had experienced more sexual dysfunction and abuse (sexual, physical, and emotional) than their nonalcoholic counterparts.

The design of this study was of particular importance. With the use of a comparison group, these data on alcoholic women can be compared to women's experience in general. Except in one area, the results of this research support previous research results found in the literature. As in Schuckit's (1972) study, there was no statistically significant difference between the alcoholic women and the nonalcoholic women in sexual activity with a partner in this study. However, the alcoholic women were more sexually active with themselves, i.e., with masturbation.

This research showed that the alcoholic women used alcohol more with sexual activity than their nonalcoholic counterparts. However, this greater usage was not associated with having sex more often with a partner. Therefore, the disinhibiting properties of alcohol seem to function more in the area of allowing greater variety of activity rather than in stimulating greater frequency of sexual activity.

The alcoholic subjects in this research reported more enjoyment of sex with alcohol than the nonalcoholic subjects. They believed that alcohol contributed to a good sexual experience. This was in sharp contrast to the significant difference between the two groups in orgasmic response. However, the data substantiated

the work of Athanasion, Shaver, and Tavris (1970) and Beckman (1970), which noted the difference between "subjective" reports of increased enjoyment and "objective" physiological response in their research subjects.

The nonalcoholic women in this study reported that alcohol rarely contributed to, yet rarely decreased, sexual enjoyment. They stated that they used it less frequently with sex than the alcoholic women. There appeared to be an association between attitude, i.e., belief about the effects of alcohol, and behavior for both the alcoholic and nonalcoholic women. This suggests that what one believes about the effect of alcohol is important in determining how one uses alcohol, that is, a woman who believes that alcohol contributes to sexual enjoyment may use it more with sexual activity, and vice versa.

The lack of orgasmic response in my study's alcoholic subjects parallels the Malatesta et al. (1979) findings that alcohol decreased physiological arousal in women. In my study, there was a significant difference between the alcoholic and nonalcoholic women in experiencing orgasm, but not a significant difference in respect to multiple orgasms. This suggests that the process of becoming orgasmic may be affected by heavy alcohol use.

This new research also confirms the earlier findings of Wilson and Lawson (1976), Malatesta et al. (1979), Athanasion et al. (1970), and Beckman (1970), which validated female differences in physiological arousal and subjective experience. However, the results of this study did not indicate greater pleasurability of orgasm with alcohol use, as described in the first two studies. The alcoholic women did not report more satisfaction with sexual responsiveness than nonalcoholic women.

The subjects in the Wilson and Lawson (1976) study were not alcoholic women, but were nonalcoholic women who experienced and reported more orgasmic satisfaction with increasing amounts of alcohol. The alcoholic women in this study used alcohol with sex most of the time (75% or more), yet they reported less satisfaction with their responsiveness that the women who used alcohol less frequently. Therefore, it appears that the alcoholic women not only had a different physiological response to the ingestion of alcohol (less orgasmic), but also a different subjective response (less satisfaction) than the nonalcoholic subjects. This raises further questions for future research regarding physiological arousal and subjective experience.

The alcoholic women in this study also reported less satisfaction with sexual relationships. This may be due at least in part of the number of past relationships they had with alcoholics (63%).

This study's data on sexual dysfunction[1] verified the findings of many previous studies: Curran (1937), Kinsey (1966), Sclare (1970), and Sholty (1979).

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[1]The question of sexual dysfunction before alcoholism was also researched in this study. Due to the difficulty of diagnosing the actual beginning of alcoholism in an individual, and considering the increasing knowledge available about the physiological and genetic aspects of alcoholism, the data gathered can only be discussed tentatively. Seventy-nine percent of the alcoholics reported having experienced sexual dysfunction before alcoholism. Of the 21% who did not experience dysfunction before alcoholism, 67% reported dysfunction during alcoholism. There was a statistically significant difference in dysfunction when comparing the alcoholic period and sobriety. However, there was no statistically significant difference in the comparison of the before-alcoholism period and sobriety. One possible explanation that requires further research is a spiraling relationship between dysfunction and alcohol use. The dysfunction experienced by alcoholic women may not be due solely to drinking, however it may have begun before alcohol became a problem, and have been exacerbated by the alcohol intake.

However, it also has clarified the types of sexual dysfunction experienced by alcoholic women and has discussed these dysfunctions within the context of current knowledge of female sexuality. These alcoholic women reported significantly more orgasmic dysfunction and general sexual dysfunction -- lack of interest, lack of arousal or pleasure, and/or lack of lubrication (formerly called "frigidity") -- than the nonalcoholic women in the study. Since only 30% of women experience orgasm through intercourse (Hite, 1976; Masters and Johnson, 1966), it was important to clarify the orgasmic response achieved by a variety of activities: masturbation, intercourse, oral stimulation, manual stimulation, etc.

In looking at the data on sexual orientation, differences were also noted between subjects' experiences in the before, during, and after phases of alcoholism. There was a marked shift in choice of sexual partners over these three periods. Before alcoholism, 74% of the women reported that they were exclusively heterosexual, 20% were bisexual, 6% were lesbians, and 3% gave no information. During the alcoholism period, 57% reported that they were exclusively heterosexual, 37% were bisexual, and 6% were lesbians. In sobriety, 66% reported that they were heterosexual, 17% were bisexual, and 17% were lesbians.

This data can be viewed from several different viewpoints: using the "disinhibition theory," one can conclude that alcohol probably permitted greater sexual freedom among these individuals, allowing them the ability to explore a variety of sexual experiences. This conclusion appears to be supported in both the data related to variety of sexual activities, and the data on choice of partners.

However, shifts in sexual self-identity from 6% lesbians before alcoholism to 17% lesbians in sobriety may also give us some insight into the role that alcohol

plays in the lives of some women while they are coming to terms with their sexual identity. Because alcohol serves to numb one's emotions, it can assist a woman in denying her emotional and physical attractions to other women. Therefore, alcohol can be an important survival mechanism in a society hostile and nonsupporting of lesbian relationships, as it helps a woman to deny her sexual identity.

This research further substantiated the findings of Evans and Schaefer (1980) and Benward and Denson-Gerber (1975) on the abuse experienced by alcoholic women. It is important to note that alcoholic women have experienced significantly more abuse (sexual, physical, and emotional) than nonalcoholic women, and that the quality of that abuse has been characterized by more violence, more frequency, more perpetrators, and that it continued for a longer duration. It is of equal importance to recognize the amount of abuse experienced by all women in this society -- a fact that cannot be ignored in this study.

Of the alcoholic women in this study, 74% experienced sexual abuse, 52% experienced physical abuse, and 72% experienced emotional abuse. By comparision, of the nonalcoholic women 50% were sexually abused, 34% were physically abused, and 44% were emotionally abused.

SEXUAL. Twenty-three of the 35 alcoholic women reported 56 instances of sexual abuse, contrasted with 37 cases reported by 17 women in the comparision group. The most prevalent perpetrators of sexual abuse for the alcoholic women were male relatives (36%), boyfriends and other unrelated but known males (20%), and unknown males (23%). For the nonalcoholic women, the majority of abuse was perpetrated by boyfriends and other unrelated males (60%). For the alcoholics,

93% of the sexual abuse was perpetrated by men and 77% of the perpetrators were known to the women. For the nonalcoholics, 100% of the abuse was perpetrated by men, and 87% of these men were known to the women.

There were 18 cases of incest (sexual activity with a family member) reported by the 22 alcoholic women who were sexually abused, accounting for 34% of the reported sexual abuse. This finding was in contrast to the comparison group where incest accounted for 16% of the sexual abuse reported. These 22 alcoholic women experienced 31 rapes, accounting for 59% of that group's sexual abuse experience. In contrast, the comparison group experienced more molestation (40%) and more attempted rape (14%) than the alcoholic group. Twice as many alcoholic women (34%) were incest and rape survivors, compared with the nonalcoholic women. While all sexual abuse is presumed traumatic, the data indicated that alcoholic women are more likely to experience the most serious sexual assaults: incest and rape.

In regard to frequency of occurrence, 36% of the sexual abuse in the alcoholic group was a single incident, 48% occurred more than once (multiple), and 16% of the abuse was chronic (occurring once a month or more for 1 year or longer). Of the cases reported by the nonalcoholic women, 19% of the sexual abuse was chronic, 35% were multiple incidents, and 46% were single incidents.

In comparing the duration (length of time over which that abuse occurred), 14% of the sexual abuse experienced by the alcoholic women occurred for more than 10 years. This was sexual abuse by the same perpetrator. There were no reports of abuse of this longevity by the nonalcoholic women.

A general analysis of the data on sexual abuse showed that alcoholic women have a wider variety of sexual abuse perpetrators, experience more instances of

abuse, and have more multiple incidents and longer duration of sexual abuse than the alcoholic women. They also have reported more incidents of incest and rape.

PHYSICAL. Fifty-one percent of the alcoholic women reported physical abuse, compared to 34% of the nonalcoholics. This difference was not statistically significant.

In general, 19 of the alcoholic women reported 34 cases of physical abuse compared to 11 of the nonalcoholic women who reported 16 incidents. The majority of the abuse was perpetrated by fathers/stepfathers, husbands, and boyfriends/unrelated males for both groups (82% versus 75%). All of the perpetrators were known by the women. For the alcoholic women, 82% of the physical abuse was perpetrated by men and 18% was perpetrated by women; fathers/stepfathers accounted for 24% of the abuse, and mothers/stepmothers for 3%. Comparatively, 75% of the perpetrators of abuse against nonalcoholic women were men, and 25% were female. Of this group, fathers accounted for 19% and mothers for 13% of the cases. Single incidents of physical abuse represented only 13% and 12% of the abuse reported by both alcoholic and nonalcoholic women, respectively. Forty-five percent of the abuse experienced by the alcoholic women was chronic (once a month or more for 1 year or more), compared to 12% chronic abuse for the nonalcoholic women.

In comparing the duration of physical abuse, both alcoholic and nonalcoholic women reported that approximately 30% of the abuse they experienced extended over a period of 10 years or more with the same perpetrator.

The types of physical abuse described by both groups of women included being hit (both with fists and objects), slapped, and thrown. In addition, the nonalcoholic women described being spanked and pulled by their hair. The

alcoholic women also experienced beatings, black eyes, unwarranted surgery, fights, arm locks, drowning attempts, and police holds. The nonalcoholic women described seven types of physical abuse compared to 13 kinds reported by the target group. While all physical abuse is an act of violence, the reports of the alcoholic women have a more violent quality to them.

While the difference was not statistically significant in the number of alcoholic and nonalcoholic women reporting physical abuse, analysis of the descriptive data shows a parallel to the sexual abuse data: again, there is a different quality in the abuse described by alcoholic women. Alcoholic women report more instances of physical abuse, of greater frequency and variety, and of a more violent nature than the nonalcoholic group.

EMOTIONAL. Seventy-one percent of the alcoholic women reported emotional abuse, compared to 44% of the nonalcoholic women. This difference was statistically significant (McNemar $p < .05$).

Twenty-four of the alcoholic women reported 77 cases of emotional abuse compared to the 33 cases reported by 17 nonalcoholic women. The perpetrators were 43% female and 57% male for the alcoholic group, and 64% male and 36% female for the comparison group. This is in sharp contrast to the perpetrators of sexual and physical abuse, who are predominantly male.

Alcoholic women reported a greater frequency of abuse than nonalcoholic women, i.e., averaging three incidents per alcoholic and two incidents per nonalcoholic. Seventy-four percent of the alcoholic women's emotional abuse was chronic, compared with 28% reported by the comparision group. In contrasting the duration data, the alcoholic women also reported a greater time span of emotional abuse with 53% occurring for more than 10 years, compared to the 31% of chronic instances reported by the nonalcoholics.

Types of emotional abuse described by both groups included degradation, ridicule, verbal abuse, and threats. In addition, the nonalcoholic women described shame and a drinking husband. The alcoholic women also experienced criticism, blame for a death, harassment, yelling, lying, unfaithfulness, withdrawal, and jealous accusations. The nonalcoholic women described six types of emotional abuse compared to 14 types reported by the alcoholic women.

The data on emotional abuse parallel the sexual and physical abuse data presented earlier. The alcoholic women have had a greater number of perpetrators and have experienced a greater number of instances of each type of abuse. Frequency of emotional abuse has been greater (similar to physical abuse) for the alcoholics and the duration of that abuse has been longer (similar to sexual abuse). The descriptive data on the kinds of emotional abuse reported indicates a wider range of abuse and a more intense abuse pattern (similar to physical abuse) for the alcoholic subjects. The sexual, physical, and emotional abuse experienced by alcoholic women appears different from that of nonalcoholic women in quantity, quality, and extent.

CONCLUSION

What do we do with this information? As treatment providers, how can we deal with these issues? I believe that our first step must be to look at ourselves: at our own attitudes, values, and knowledge about alcohol and drug use. We also need to look at our own attitudes towards violence and abuse. For example, is our first reaction to an incident: "I wonder what she did to deserve it?" Or do we honestly believe that no one has the right to abuse another person, whether of not the individual is drunk or sober? The chemically dependent woman is filled with feelings of guilt, shame, fear, denial, low self-esteem, and isolation. Her

feelings of guilt are often compounded by feelings of shame regarding her sexual experiences (often labeled as "escapades" or "promiscuous"), her lack of sexual functioning (again negatively labeled as "frigid"), and the accumulated abuse she has experienced in her life (for which she somehow feels responsible). Yes, sexuality and chemical dependency are intertwined in women's lives... it's time for us to acknowledge both in treatment.

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"Sex and Alcohol: What Do Women Tell Us?" discusses the relationship between sex and alcohol in women's lives, based on the existing literature -- including Dr. Covington's own research. Focus is on acquainting counselors with women's issues and on the importance of dealing with these issues in alcoholism treatment programs.

This work was presented twice in 1982: at the National Alcoholism Forum in Washington, D.C. and at the International Congress on Alcoholism and Drug Dependence in Morocco.

SEX AND ALCOHOL:
WHAT DO WOMEN TELL US?

In alcoholism treatment programs, we often discuss the "no-talk rules" that alcoholic families have. No matter how blatant the alcoholism may be, families excuse, ignore, and deny the problem. We in the field of alcoholism are also guilty of denial. For, until recently, the issue of sexuality has been ignored in alcoholism treatment programs. And, to quote Adrienne Rich, feminist writer and poet, "Lying in done with words, and also with silence." This is particularly relevant for women, because for years we have lied about our lives by silence.

The area of sexuality is pertinent in the treatment of the woman alcoholic because this issue is part of the alcoholic woman's life experience. We're all familiar with the data that indicates the low self-esteem of the alcoholic woman -- her shame and her guilt. We know that she carries more shame than the alcoholic man due to the stigma of being an alcoholic woman. These feelings are often compounded by the feelings she carries regarding her sexual experiences (often described as escapades), her lack of sexual functioning, and the abuse she has received in her life (for which she generally feels responsible).

The following is data on 35 alcoholic women who participated in my doctoral research project. The statistics will help to indicate the scope of the problem by pointing out how prevalent and, therefore, important these issues are in the recovery and treatment of the woman alcoholic.

The population consisted of 35 Caucasian recovering alcoholic women from San Diego and Orange Counties, California, matched with 35 nonalcoholic women. The women were matched on age, education, marital status, and religious background. They ranged from 19 to 68 years of age, with a mean age of 38 years. The

majority of these women were from middle-class backgrounds. Their level of education ranged from grade school to advanced degree, with the largest number having some college education. More than two thirds were employed outside the home in occupations which ranged from professional to service worker. There were five homemakers and one student in the sample. Their religious backgrounds included 10 Roman Catholics, 24 Protestants, and 1 Jew. Their current marital status was 9 single women, 1 widowed, 9 divorced, 1 separated, 11 married, and 4 living with sexual partners. These women were newly recovering with 3 to 12 months of sobriety, with the mean length of sobriety being 7.5 months. The time during which these women drank alcoholically extended from 1 to 25 years, with the mean being 9½ years. Their sexual orientations during alcoholism were 20 heterosexual women, 13 bisexual, and 2 lesbians. The sample was drawn from volunteers in Alcoholics Anonymous, recovery homes, and hospital treatment programs.

I'd like to begin by first looking at the relationship between the alcohol use and female sexual experience and function. The belief that alcohol is an aphrodisiac has existed throughout history. In reality, it is not. However, alcohol has long been associated with sexual behavior. The prevailing view of how alcohol enhances sexual activity is the disinhibition hypothesis. The theory is that alcohol, as a central nervous system depressant, progressively depresses higher brain functions that control or inhibit sexual behaviors (1). This theory was supported by the reports of the alcoholic women. The alcoholic women reported a greater variety of sexual experience than nonalcoholic women. There was a significant difference both in participation in what conservatives might call "traditional" sexual activity (i.e., intercourse) and in less "traditional" activity

(i.e., oral and anal sex). Alcohol seems to allow alcoholic women to feel freer to engage in a wider variety of sexual activities. While early studies reported "promiscuity" among alcoholic women, this was neither substantiated in later research (2) nor in this study. There was no significant difference between the alcoholic women and the controls in sexual activity with a partner. However, the alcoholic women were more sexually active with themselves (i.e., masturbation). While the alcoholic women reported a greater use of alcohol (and all other drugs except hallucinogens) in conjunction with sex, this greater usage was not associated with having sex more often with a partner. The disinhibiting properties of alcohol seem to function more in the area of variety of activity than in frequency.

The alcoholic women also reported greater enjoyment of sex with alcohol than nonalcoholic women. They believed that alcohol contributed to a good sexual experience. This is in sharp contrast to the significant difference between to two groups in orgasmic response. This data was substantiated by the work of Athanasion et al. (3) and Beckman (4), which noted the difference between "subjective" reports of increased enjoyment and "objective" physiological response. The alcoholic women used alcohol more with sex and reported that it made sex more enjoyable. The nonalcoholic woman reported that alcohol rarely contributed to a good experience, yet rarely decreased enjoyment, and they used alcohol less frequently with sex. There was an association between attitude (belief) toward alcohol and behavior for both the alcoholic and nonalcoholic women. This suggests that what one believes about the effect of alcohol is important to how one uses alcohol.

The alcoholic women's lack of orgasmic response paralleled Malatesta, Pollack, and Crotty's (5) findings that alcohol decreased physiological arousal in women.

There was a significant difference between the alcoholic and nonalcoholic women in experiencing orgasm but no significant difference with respect to multiple orgasms. This would suggest that the process of becoming orgasmic is affected by heavy alcohol use.

The Wilson and Lawson (6) and the Malatesta, Pollack, and Crotty studies (as well as the Athanasion and Beckman studies mentioned earlier) validated the differences found in physiological arousal and subjective experience. However, the results of this study did not indicate greater pleasurability of orgasm with alcohol use as described in the first two studies. The alcoholic women did not report more satisfaction with sexual responsiveness than nonalcoholic women. This may indicate another difference between alcoholic and nonalcoholic women. The subjects in the Wilson study were not alcoholic women. They were nonalcoholic women who experienced and reported more orgasmic satisfaction with increasing amounts of alcohol. The alcoholic women in this study, although they used alcohol with sex most of the time (75% or more), reported less satisfaction with their responsiveness than the women who used alcohol less frequently. It appears that the alcoholic women not only had a different physiological response to the ingestion of alcohol but also a different subjective response.

The alcoholic women also reported less satisfaction with sexual relationships. This may partially be due to the number of past partners who had alcohol problems (63% compared to 37% of the nonalcoholic women). It is very difficult for two alcoholics to have an intimate relationship (let alone a sexually satisfying one) when an alcoholic has only one real love relationship -- the bottle.

Next I would like to discuss the data on dysfunction. The alcoholic women reported significantly more sexual dysfunction than the nonalcoholic women (85%

versus 59%). Information was gathered on the following types of dysfunction: 1) lack of sexual interest, 2) lack of sexual arousal or pleasure, 3) painful intercourse, 4) vaginismus, 5) lack of orgasm, and 6) lack of lubrication. Note that the term "frigidity" is not used, although we often see alcoholic women referred to as "frigid" in the literature. As defined by Kaplan (1), there are basically two categories of sexual dysfunction: general sexual dysfunction, formerly called frigidity -- which is characterized by lack of erotic feelings or interest, lack of arousal and/or lack of lubrication -- and orgasmic dysfunction which is characterized by the inability to have an orgasm. This condition is called preorgasmia -- meaning the woman hasn't had an orgasm, yet.

The question of sexual dysfunction before alcoholism was also researched. Due to the difficulty in assessing when alcoholism begins, the data gathered can only be discussed tentatively. The alcoholic women defined for themselves "when alcohol became a problem." According to their personal assessment of that point in time, they reported information about their sex lives. Seventy-nine percent of the alcoholics reported experiencing sexual dysfunction before alcoholism. Of the 21% who did not experience dysfunction before alcoholism, 67% reported dysfunction during alcoholism. There was a significant difference in dysfunction between the alcoholic period and sobriety and no significant difference between the before alcoholism period and sobriety. This implies a spiralling relationship between dysfunction and alcohol use. The dysfunction experienced by alcoholic women may not be due solely to their drinking. It may have begun before alcohol became a problem and then have been exacerbated by the alcohol intake.

In looking at the data on sexual orientation, changes were also noted between the before, during, and after phases of alcoholism. There was a shift in choice

of sexual partner during these three periods. According to their reports, before alcoholism, 26 of the women were exclusively heterosexual, 7 were bisexual, 1 a lesbian, and for 1 we have no data. During the alcoholism period, 20 were exclusively heterosexual, 13 bisexual, 2 lesbian. In sobriety, 23 are heterosexual, 6 bisexual, and 6 lesbian. This data can be interpreted from several different viewpoints.

Using the disinhibition theory of alcohol use, we can see that perhaps alcohol permitted greater sexual freedom and the ability to explore a variety of experiences. This appears to be true not only in the data related to variety of sexual activities, but also in choice of partner.

The shift in identity from one lesbian before alcoholism to six lesbians in sobriety also gives us some idea about the role that alcohol plays for some women in the process of coming to terms with their sexual identity. Because alcohol serves to numb one's emotions, it can assist a woman in denying her emotional and physical attraction to another woman. Therefore, alcohol can be an important survival mechanism in a society that is hostile and nonsupporting of lesbian relationships, since it helps a woman to deny her sexual identity.

So what do we know thus far about the sexual experience of alcoholic women? Most alcoholic women participate in a greater variety of sexual activities, are more sexually active with themselves, and use alcohol more often when sexual than nonalcoholic women do. Although they believe that alcohol contributes to a good sexual experience, alcoholic women have more sexual dysfunction and less satisfaction with sexual response and relationships. For the lesbian, alcohol plays an additional role. It may interfere with realizing her sexual identity. The data tells us that sexuality is an issue that we must deal with in treatment programs.

This is part of the alcoholic woman's life experience. These issues in sexuality are not isolated to the alcoholic women, they are part of all women's lives. For the alcoholic woman, the problems are exacerbated and the issues are more complicated.

I would also like to share the data on abuse reported by alcoholic and nonalcoholic women. The issue of violence, like that of sexuality, is a dominant theme in the experience of the alcoholic woman. Also let me comment here that sexual abuse -- incest, rape, molestation -- is an act of violence, not passion. These are not sexual acts but acts of aggression and social control. Of the alcoholic women studied, 74% experienced sexual abuse, 52% experienced physical abuse, and 72% experienced emotional abuse. This was in comparison to the nonalcoholic women who reported 50, 34, and 44% respectively.

Twenty-three of the 35 alcoholic women reported 56 instances of sexual abuse compared to 37 cases reported by 17 women in the control group. The most prevalent perpetrators of abuse for the alcoholic women were male relatives (36%), boyfriends and unrelated males (20%), and unknown males (23%). For the nonalcoholic women, the majority of abuse was perpetrated by boyfriends and unrelated males (60%). For the alcoholics 93% of the sexual abuse was perpetrated by men; 77% of them were known by the women. For the nonalcoholics, 100% of the abuse was perpetrated by men and 87% of these men were known.

The 22 alcoholic women who were sexually abused reported 18 cases of incest. Incest (sexual activity with a family member) accounts for 34% of the sexual abuse in this group. This is in comparison to the controls where incest accounted for 16% of the sexual abuse cases. The 22 alcoholic women also experienced 31 rapes; rape accounted for 58% of their sexual abuse experience. In comparison, the

controls experienced more molestation (41%) and more attempted rape (14%). While all sexual abuse is traumatic, alcoholic women are more likely to experience the most serious sexual assaults: incest and rape.

In regard to frequency, alcoholic women reported that 36% of the sexual abuse was a single incident, 48% occurred more than once (multiple), and 16% of the abuse was chronic (occurring once a month or more for one year or longer). The nonalcoholic women experienced 19% of their sexual abuse chronically and 35% as multiple instances. In comparing duration, 14% of the sexual abuse experienced by the alcoholics occurred for 10 years or more; no reports of abuse of this longevity were made by the nonalcoholics.

An analysis of the data on sexual abuse shows that alcoholic women are exposed to a wider variety of perpetrators, experience more instances of abuse, and have more multiple instances and longer duration of sexual abuse. They also report more incest and rape.

Nineteen of the 35 alcoholic women reported 34 cases of physical abuse compared to 11 of the nonalcoholic women reporting 16 cases. The majority of the abuse was perpetrated by fathers/stepfathers, husbands, and boyfriends/unrelated males for both groups. For the alcoholic women, 82% of the physical abuse was perpetrated by men and 18% was perpetrated by women. Fathers accounted for 24% of the abuse and mothers for 3%. Single incidents of physical abuse represented only 13% and 12% of the abuse reported by the alcoholic and nonalcoholic women, respectively. Forty-five percent of the abuse experienced by alcoholic women was chronic (once a month or more for one year or longer) compared to 12% chronic abuse for nonalcoholic women. Both alcoholic and nonalcoholic women reported that approximately 30% of the abuse extended for a period of 10 years or longer.

The types of physical abuse described by both groups of women included being hit (both with fists and objects), slapped, and thrown. In addition, the nonalcoholic women described being spanked and pulled by their hair. The alcoholic women also experienced beatings, black eyes, malpractice surgery, fights, arm locks, drowning attempts, and police holds. The nonalcoholic women described 7 types of physical abuse compared to 13 kinds reported by the experimental group. While all physical abuse is an act of violence, the reports of the alcoholic women have a more violent quality to them.

Even though the difference was not significant in the initial report of physical abuse, the descriptive statistics essentially parallel the sexual abuse data. There is a different quality in the abuse described by alcoholic women. Alcoholic women report more instances of physical abuse, greater frequency of abuse, a greater variety of and more violent physical abuse.

Seventy-one percent of the alcoholic women reported emotional abuse compared to 44% of the nonalcoholic women. Twenty-four of the alcoholic women reported 77 cases of emotional abuse compared to the 33 cases reported by 17 nonalcoholic women. The perpetrators were 43% female and 57% male for the alcoholic group and 64% male and 36% female for the controls. This is in sharp contrast to the perpetrators of sexual and physical abuse who are predominantly male. Alcoholic women reported a greater frequency of abuse than nonalcoholic women. Seventy-four percent of their emotional abuse was chronic (occurring once a month or more for one year or longer) compared with 28% reported by the controls. In comparing duration, the alcoholic women also reported a greater time span of emotional abuse with 53% occurring over 10 years or longer. This is in contrast to the 31% of chronic instances reported by the controls.

The types of emotional abuse described by both groups included degradation, ridicule, verbal abuse, and threats. In addition, the nonalcoholic women described shame and a drinking husband. The alcoholic women also experienced criticism, blame for a death, harassment, yelling, lying, unfaithfulness, withdrawal, and jealous accusations. The nonalcoholic women described 6 types of emotional abuse compared to the 14 kinds reported by the alcoholic women.

The data on emotional abuse parallels the sexual and physical abuse data. Alcoholic women experience a greater number of perpetrators and a greater number of instances of abuse. The frequency of emotional abuse is greater (similar to physical abuse) and the duration is longer (similar to sexual abuse). The descriptive data on the kinds of emotional abuse indicates a wider range and more intense abuse (similar to physical abuse). The sexual, physical, and emotional abuse experienced by alcoholic women is different from that of nonalcoholic women not only in quantity but also in quality and extent.

What do we do with this information? As treatment providers, how can we deal with these issues? I believe our first step is to look at ourselves. In the area of sexuality we need to look at our own attitudes, values, knowledge, and skills. We need to assess our own ability to give information and to be comfortable with sexual issues. We also need to look at our attitudes towards violence and abuse. Is our first reaction: "I wonder what she did to deserve it?" Or do we honestly believe that no one has the right to abuse another person, whether she is drunk or sober? And since many of us (the professionals in the alcoholism field) are recovering and/or grew up in alcoholic families, we need to deal with abuse issues in our own lives. So, after we look at ourselves and make some assessments, what do we provide for women?

Women need to be in groups with other women where they can feel safe, where they can share their experiences and their pain and their secrets. This is a place where what a woman says is her truth because it is her experience and her reality. A women's group is a place where the silence surrounding sexuality and abuse can be broken. Often you'll hear counselors state that the issues are "too heavy" and can't be dealt with in early sobriety. I disagree. They are part of the life experience of a woman alcoholic and must be dealt with if sobriety is going to be maintained. Yes, these are sensitive areas and they can be dealt with in a sensitive manner. For example, one can begin a session on sexuality by using questions about early sex education and about a woman's first experience with menstruation. As women start sharing, they find the commonality of their life experiences. And by the sharing of experiences, the trust level builds. The topic of body image can then be discussed. Let the women explain how they feel about their bodies. Have them describe what they like physically about themselves and what they see as physically negative about themselves. A session on violence can begin by asking if anyone knows a woman who has been raped and discussing what that was like for her. Let the women explain what they do, how they adjust their lives in order to protect themselves. Explore how women are portrayed and used by the media, then progress into how we have been used by others -- our fathers, brothers, husbands, and lovers. The facilitator moves from the least sensitive areas to gradually more intimate issues.

When discussing sexuality we need to be able to give accurate information. As women we have been denied knowledge of our bodies. Research for years has been done by men, and our sexuality had been defined by male standards. If we look historically to the 1880s, women were considered to be nonsexual beings; now

we can look at the 1980s when women are supposed to have multiple orgasms. He have progressed from Freud's idea of frigidity and his belief that the mature orgasm was a vaginal orgasm, through the Masters' and Johnson model which has the clitoral orgasm as a standard, to today where we have new information regarding the Grafenberg spot and female ejaculation. So we are still learning about women's bodies and this kind of information needs to be shared with all women. As treatment providers, we must be knowledgeable about current information and willing to share it, so that women can then relate it to their own sexual experience.

Sexuality is an inherent part of our lives; broadly defined, it is how we see ourselves in the world. It is an issue that must be dealt with in treatment programs designed for sobriety. Sobriety means to live one's life fully, and sexuality cannot be separated out and ignored. In this study, the dysfunction and lack of satisfaction data indicates this is an issue in alcoholic women's lives that needs to be addressed. While 79% reported dysfunction before alcoholism and 85% during alcoholism, 74% reported dysfunction in sobriety. This fact, coupled with the information that the women wished to be more sexually active than they were, indicates the importance of this area to women. Also, 70% of the alcoholic women felt they could benefit from sexual counseling in their recovery. (This compared to 46% of the controls.)

The area of intimacy and relationships is a problem area for all alcoholics. As mentioned before, the major love relationship is with the bottle. Alcohol has been used to modify emotions (usually for years); therefore, feelings are strangers to the newly recovering person. The issue of intimacy is more complex for the woman alcoholic. According to this study, the abuse that she has

experienced is predominantly perpetrated by those close to her, thus she has learned not to trust. Her experience has been that those who are supposed to be caring, loving, and nurturing are often one's abusers. Since, according to this study, the most violent abuse (sexual and physical) was almost solely perpetrated by men, her heterosexual relationships are going to be affected. It is crucial that the issue of abuse experienced by women be dealt with in treatment. When staff is not prepared in this specialized area of counseling, then resources for referral must be developed.

Alcoholic women are filled with guilt, shame, fear, denial, low self-esteem, and isolation. These feelings are magnified in the abused woman. In addition, the findings of this study indicate that women have special issues and unique experiences in their lives. Therefore, it is imperative that women be in treatment groups with other women where they can learn to love and value themselves. This is a way to break through the barriers to recovery.

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"Alcohol and Family Violence" was presented in 1983 at the 29th International Institute on the Prevention and Treatment of Alcoholism in Zagreb, Yugoslavia.

Based on the literature and on the author's research, this paper explores gender differences between the "victims" and perpetrators of violence in relation to alcohol consumption and dependence, offering a theoretical analysis of the differences found.

ALCOHOL AND FAMILY VIOLENCE

Violence.....family.....surely it is totally irrational to find a link between these two words, for they stand for such opposite concepts! Everyone knows that implicit in the concept of family is assurance of a safe, nurturing, supportive environment. How can that have any association with the aggression and hostility explicit in violence? What could possibly be happening in a society where such a linkage has, in fact, come about?

As American society has evolved, the prevailing atmosphere in many of our communities requires that doors and windows be kept locked, and that we participate in self-defense classes in order to protect our homes and ourselves from violent intrusion from the outside. Crime statistics show that homicide, rape, assault, and robbery increased by 50% between 1975 and 1980. Such "epidemic" growth, were it to occur in the form of a disease, would be cause for immediate establishment of control centers across the country -- if this were a germ destroying people. That violence is not treated as a priority issue is an indictment in itself.

We already know that alcohol plays a key role in the perpetration of crime in the United States. In the following statistics from the National Council on Alcoholism (1) the relationship between alcohol use and crime is obvious:

a. in robbery cases, 72% of the offenders had been using alcohol;

b. in murder cases, 86% of the offenders and 40% to 60% of the victims had been using alcohol;

c. in rape cases, 50% of the rapists had been using alcohol; and

d. in assault cases, 72% of the offenders had been using alcohol.

While many acknowledge the pervasiveness of crime, there is a continuing denial of the fact that abuse has occurred, and is continuing to occur, at an alarming rate within families. The reality of today's living is that we are not safe even with those we know. In fact, the probability of suffering abuse from someone we know is greater than from a stranger. The sad fact is that what is happening within the microcosm of the family is a direct reflection of the violence pervading our culture and the world.

Conflict is an inevitable part of all human interaction. Paradoxically, the more intimate the bond between people, the higher the level of potential conflict. Since the family is one of the most intimate connections, a particularly high level of potential conflict exists in its relationships. However, as long as conflict within the family is ignored or simply dismissed as "wrong," there can be no impetus to discover and learn effective techniques for nonviolent resolution of such conflict. Violence in the family reflects current cultural mores and social violence, exemplified by physical punishment in schools, the acceptance of the death penalty, and the espousal of war as a solution to conflict. The portrayal of violence that pervades the media "normalizes" such behaviors. Thus, our society has apparently accepted violence as a legitimate way of solving problems.

There is growing acknowledgement of the association between family violence and alcohol use. While the research is still scarce and not all the data is consistent, studies to date indicate the following:

- alcohol is a factor in 50% of the fights or assaults in U.S. homes;
- alcohol is a factor in 40% of all family court problems;
- alcohol has an association in 34% of the cases of child abuse (2);
- 50% of alcoholic parents are child abusers (3);

- 66% of children in alcoholic homes are abused (7);
- 67% of sexually aggressive acts against children involve alcohol use;
- 80% to 90% of husbands who batter use alcohol (4, 5);
- 70% of battered women are frequent drinkers (8);
- 39% of sexually aggressive acts against women involve alcohol use;
- 35% of incest perpetrators are heavy drinkers (6);
- 50% of incest victims are from alcoholic homes (7).

One explanation of the relationship between alcohol and violence is based on the premise that the disinhibiting effects of alcohol dissolve the super ego, and one's control system becomes dysfunctional. In addition to lowering inhibitions, alcohol also has a long-term agitating effect on the drinker, causing sleeplessness, irritability, increase in aggressive fantasies, and impairment of cognitive functions. However, whatever the neurophysiological changes that occur in an individual using alcohol, a clear cause-effect relationship between alcohol and violence has not yet been established. It has been postulated that some abusers use alcohol deliberately, in order to act out their aggression. In cases of sexual abuse, which are often premeditated, this is particularly evident.

In alcoholism research to date, while no set descriptive patterns of an alcoholic personality or the alcoholic family have evolved, there are visible trends, i.e. common threads. For example, there appears to be a cross-generational transmission of both alcoholism and violence in families. In this generational cycle of family violence, males who were abused as children become abusive adults. Women who were physically abused as children become child abusers and/or victims of an abusive partner. Also, women who are incest survivors often marry men who perpetrate incest.

As one scrutinizes the data on social and family violence more closely, it is glaringly apparent that gender differences exist between the survivors and the perpetrators of family violence. In general, men are the perpetrators and women are the survivors. However, in order to understand specifically the role that abuse plays in the lives of women, and to see another view of the relationship between alcohol and violence, I would like to discuss the results of my own research on the subject.

Following is data collected on 70 American women -- 35 recovering alcoholics and 35 nonalcoholic Caucasian women from San Diego and Orange Counties in California. The research focused on a number of aspects of the subjects' lives, including sexual experience and dysfunction, sexual orientation, and abuse -- physical, sexual, and emotional. For purposes of the study, the two groups were paired on age, education, marital status, and religious background.

Averaging 38 years in age, the majority of these women were from middle-class backgrounds. Their education levels ranged from grade school to advanced graduate degrees, with the largest group reporting some college. Over two-thirds of the subjects were employed outside the home, at occupations ranging from service-worker to professional positions. Sixty-eight percent were Protestants, 29% were Roman Catholics, and 3% were Jewish. Forty-two percent were married or living with a sexual partner, 26% were single, the same number were divorced, 3% were widowed, and the same number were separated.

For the alcoholic women, the average length of sobriety was 7.5 months, having drunk alcoholically an average of 9½ years. This group volunteered to participate in the research from AA, recovery, and hospital treatment programs in the area. Fifty-seven percent were heterosexual, 37% were bisexual, and 6% were lesbians.

It appears that simply being born a woman in this world puts one at high risk of becoming a victim of some form of abuse -- physical, sexual, and/or emotional. Certainly this was reflected in the experiences of my research subjects.

Surely by now it is common knowledge that sexual abuse, i.e. incest, rape, and molestation, is an act of violence, not passion! These are not sexual acts, but rather acts of aggression and social control. Violence and sexuality are dominant themes in the experiences of the alcoholic woman in this study -- 74% had experienced sexual abuse, 52% had experienced physical abuse, and 72% had experienced emotional abuse. By comparison, of the nonalcoholic subjects 50% reported sexual abuse, 34% physical abuse, and 44% emotional abuse. These different types of abuse, although experienced by both groups of women to a startlingly significant extent, appear different for the alcoholic women in quantity, quality, and extent. The alcoholic women were abused by more perpetrators, had more instances of abuse, and for a longer time span in their lives.

The most prevalent perpetrators of sexual abuse on the alcoholic women were male relatives and unknown males, while boyfriends and other unrelated, but known, males abused them in 20% of the instances recorded. For the nonalcoholic group, 60% of the instances were perpetrated by the latter group. In combining both groups of responses, 93% to 100% of the sexual abuse perpetrated on these women was by males, and 77% to 87% of the perpetrators were known to the women.

Incest, i.e. sexual activity with a family member, accounted for 34% of the reported sexual abuse among the subjects. For the nonalcoholic population, 16% of their sexual abuse involved incest. Fifty-eight percent of the alcoholic group's sexual abuse experience involved rapes. The comparison group experienced more

instances of molestation (41%) and more attempted rapes (14%) than the alcoholic group. Twice as many alcoholic women than nonalcoholic women were incest and rape survivors! While all sexual abuse is traumatic, the data indicated that alcoholic women are more likely to experience these most serious of sexual assaults.

In regard to frequency, combining the data on the sexual abuse perpetrated on these women, 16% to 19% of the abuse occurred one or more times a month for one year or more (chronic), 35% to 48% of the incidents occurred more than once, and 36% to 46% were single incidents.

As for the length of time (duration) over which sexual abuse occurred, 14% of the sexual abuse experienced by the alcoholic women went on for more than 10 years, and came from the same perpetrator. None of the nonalcoholic subjects reported this kind of abuse longevity.

A summary of the data on sexual abuse showed that the alcoholic group was subjected to a wider variety of sexual abuse perpetrators, experienced more instances of abuse, and had more multiple incidents and longer duration of sexual abuse than the nonalcoholic women. The alcoholics also reported more incidents of incest and rape.

Data on the physical abuse experienced by these women was also gathered in this research, with 51% of the alcoholic women and 34% of the nonalcoholic women reporting physical abuse. In general, the majority of abuse was perpetrated by fathers/stepfathers, husbands, and boyfriends/unrelated males on both groups of women. In all cases, the perpetrators were known to the women, with 82% of the physical abuse coming from men and 18% coming from women --i.e., mothers and stepmothers. Forty-five percent of the physical abuse experienced by the alcoholic

women occurred once a month or more over one year or more (chronic). Approximately 30% of the physical abuse for both alcoholic and nonalcoholic subjects extended over 10 years or more, and came from the same perpetrator(s).

In summarizing the physical abuse data, while there was not a statistically significant difference between the number of alcoholic and nonalcoholic women reporting physical abuse, there is a different quality in the abuse described by the alcoholic women. The alcoholic women reported more instances of physical abuse, of greater frequency and variety, and of a more violent nature than the nonalcoholic women.

Seventy-one percent of the alcoholic women reported emotional abuse, compared to 44% of the nonalcoholic women, which was statistically significant. In sharp contrast to the data on sexual and physical abuse, where the perpetrators are predominantly male, perpetrators of emotional abuse were 43% female and 57% male for the alcoholic group, and 36% female and 64% male for the nonalcoholic group. Paralleling the physical abuse data, the alcoholic group reported a greater frequency of abuse (averaging 3:2), nearly three times as much chronic abuse, and nearly twice as many cases of emotional abuse enduring for 10 years or more, paralleling the sexual abuse data.

Overall, the data on emotional abuse is similar to the sexual and physical abuse data presented earlier. The alcoholic women reported a greater number of perpetrators of abuse and experienced more instances of each type of abuse. They also reported a wider range of types of abuse and, similar to the physical abuse data, more intense abuse.

It is important to note the age when abuse began in the lives of these women. For example, among subjects who had been sexually abused, 100% of the alcoholic

women and 65% of the nonalcoholic women had been abused by age 10. For those physically abused, 74% of the alcoholic subjects and 82% of the nonalcoholic subjects had been abused by age 10. And for those who had been emotionally abused, 100% of both groups had experienced their first abuses by age 10; 100% of the abused women in both groups had experienced abuse by age 20.

While statistics, in and of themselves, tend to be boring, the abuse statistics on women and children in the U.S. are too alarming to be taken for granted:

- By age 18 -- 38% of all female children have been sexually assaulted;
  -- 16% of these incidents have been incest (9);
  -- 7% of the male population have been sexually molested (10);
- 70% of the female prostitute population and 80% of the female drug addicts are incest victims as children (11);
- Over 90% of child sexual abuse is committed by heterosexual men against female children (12);
- 75% of the sexual abuse against children is perpetrated by a family member, or by someone known to the child (12);
- That 1.8 million women are abused annually is considered a conservative estimate... more realistically it is twice that figure (13).

In the State of California alone:

- 50% of the married women are assaulted by their husbands sometime during their married life (14).

In Los Angeles County alone:

- One out of every 2.8 women over the age of 14 have been raped at least once in their life (15).

Figures corroborating the results found in my research are available in the following 1982 studies of female substance abusers in hospital-based treatment programs:

At the Eagleville, Pennsylvania, program:

- 60% of the women had been physically abused;
- 93% had been emotionally abused;
- 73% had been sexually abused, with
- 47% having been incest survivors

At Phoenix General Hospital in Arizona:

- 63% of the women had been victims of rape or incest before the age of 14.

All of this evidence attests to the fact that misogyny, hatred of women, is not just a theory of the past or simply a feminist concept. It is "alive and well" in our modern society, both a pervasive and constant issue for females of all ages to deal with.

Public acknowledgment of this information can allow consideration of the possibility that, for some women, the use of alcohol and other drugs has become a way to deal with the emotional pain resulting from earlier abuse by someone close to them, someone they trusted. Early abuse often leads to continual victimization.

Let us now move to the topic of incest, the most hidden and traumatic form of abuse. These cases are where the children pay for the affection and attention that should be freely given. From a therapeutic viewpoint, incest is best viewed along a continuum -- from covert to overt incest. Covert incest is characterized by household voyeurism, ridicule of developing bodies, "inadvertent" touching,

sexual hugs, and the use of sexualizing/objectifying language. Overt incest involves blatant sexual contact, i.e. fondling, french kissing, fellatio, penetration, and intercourse.

Judith Herman's study on incest (6) included a description of the dynamics of incest and an analysis of the effects of this experience on the female survivors:

> . . . these women alone suffered the consequences of their psychological impairment. Almost always, their anger and disappointment were expressed in self-destructive action: in unwanted pregnancies, in submission to rape and beatings, in addiction to alcohol and drugs, in attempted suicide.
>
> Thus did the victims of incest grow up to become archetypally feminine women: sexy without enjoying sex, repeatedly victimized yet repeatedly seeking to lose themselves in the love of an overpowering man, contemptuous of themselves and of other women, hard-working, giving, and self-sacrificing. Consumed with rage, they nevertheless rarely caused trouble to anyone but themselves. In their own flesh, they bore repeated punishment for the crimes committed against them in their childhood. (6, p. 108)

Daughters of covertly seductive fathers exhibited a milder form of the incest victim syndrome in adult life. Like the overt incest victim, they tend to feel contempt for womankind, and to hold men in high regard. They had many difficulties in establishing rewarding personal or sexual relationships --which related to their own lack of self-respect. However, they were spared some of the worst punishments of the overt incest victim. For example, it was not characteristic of them to feel obligated to submit to physical abuse or to attempt to destroy themselves.

In their descriptions of family dynamics, striking similarities between covert and overt incest victims became apparent. Generally, both groups came from traditional patriarchal families, where the physical and economic control of the family rested with the father. These fathers were usually respectable citizens in their communities. Sex roles were rigidly and traditionally defined in these

families; conservative religious attitudes and sexual morality, including a rigorous double standard of sexual behavior, prevailed.

The overtly incestuous family represents the pathological extreme of male dominance, while the covertly incestuous family exhibits a lesser, more commonplace variety of that characteristic. In both types of families, daughters learn that fathers rule, that mothers submit, and that the ordinary female condition is contemptible.

One important difference between the covertly and overtly incestuous family is the power of the mother as an agent of child protection. Families in which mothers were rendered unusually powerless through battering, physical disability, mental illness, alcoholism, or the burden of repeated childbearing, appeared to be at particularly high risk for the development of overt incest. However, families where a more equal balance of power was preserved, overt incest did not develop, despite the apparent sexual interest of the fathers in their daughters. Mothers who were able to function competently in their traditional roles, and who did not submit to abuse themselves, effectively protected their daughters from incest, even though they and their daughters were often bitterly estranged. Therefore, the most effective barrier to overt incest appears to be the degree of social control exerted by the mother, not a father's impulse control.

Although incest may be in the early stages of discussion in the U.S., it is a phenomenon that occurs in all cultures. I would hypothesize that in any culture, the greater the degree of male supremacy and the more rigid the sexual division of labor, the more frequent one might expect the taboo on father-daughter incest to be violated. Conversely, the more egalitarian the culture, the more the child-rearing is shared by men and women, the less one might expect to find overt

incest between father and daughter. The same logic would apply to particular families within any one culture. My hypothesis cannot be confirmed or disproved by cross-cultural studies on the prevalence on incest, since no reliable data is available for comparison. However, this point of view has been validated through the study of incestuous families, where father-daughter incest appears to be only a single manifestation of paternal rule.

As treatment providers, how do we use this information? We must be willing to acknowledge the possible existence of abuse within the families we see. We must be aware that our clients may be either survivors or perpetrators of abuse. We can no longer be part of the denial system that permeates alcoholism and family violence. Nor must we assume that the condition will be alleviated in sobriety. Perpetrators of violence often continue physical and sexual abuse after they have stopped drinking.

One of the issues in alcoholism treatment is the need for the client to deal with the past (16). The alcoholic must come to accept his/her past precisely as is happened. The recovering person must also accept the likelihood that past events may continue to affect his/her present life situation. Perpetrators of abuse need to accept responsibility for their behavior.

Treatment programs in the U.S. that specialize in work with families in which sexual abuse has occurred (17) agree on the following strategies:

1. Report the situation to the criminal justice system;
2. Remove the father from the family;
3. Utilize parent self-help groups, i.e., Parents United, Families Re-United; Parents Anonymous.
4. Strengthen the mother-daughter relationship.

What about the alcoholic woman who has been abused? These women need to be in treatment groups with other women where they can feel safe, and where they can share their experiences, their pain, and their secrets. This is a place where what a woman says is HER TRUTH because it is HER experience and HER reality. A woman's group is a place where the silence surrounding abuse can be broken, and where this issue can be dealt with in a sensitive manner.

A session on violence can begin by asking if anyone knows a woman who has been raped, and discussing what the experience was like for her. Encourage the women to share what they do in adjusting their lives to protect themselves. Explore how women are portrayed in and used by the media, then progress into a discussion of how we have been used by others, i.e., our fathers, brothers, husbands, and lovers. A facilitator can move the group discussion from the least sensitive areas gradually into more intimate issues. As women start sharing these experiences, they find the commonalities in their lives. Their sense of isolation and alienation can be broken. Through the process of sharing their experiences, the trust level builds between them.

The area of trust and intimacy in relationships is a problem area for all alcoholics. The major love relationship in an alcoholic's life is with the liquor bottle. Often the alcoholic has been using alcohol for years to modify her/his emotions. Therefore, feelings can be "strangers" to the newly recovering person.

The issue of intimacy is more complex for the woman alcoholic. My research shows that the abuse she has experienced is predominantly perpetrated by those close to her. Thus, she has learned not to trust. Her experience has been that those who are supposed to be caring, loving, and nurturing are often her abusers. Since her most violent sexual and physical abuse was almost solely perpetrated by men known to her, her heterosexual relationships are bound to be affected.

It is crucial that the issue of abuse experienced by women be dealt with in alcoholism treatment. If staff are not trained for this specialized area of counseling, then resources for referral must be developed.

Alcoholic women are filled with guilt, shame, fear, denial, low self-esteem, and isolation. These feelings are magnified in the physically, sexually, and emotionally abused woman. Women have special issues and unique experiences to deal with in their lives. Therefore, it is imperative that women be in alcoholism treatment groups with other women, where together they can learn to love, value, and trust themselves -- and each other. This is a way to break through the barriers to recovery.

The information in this article has dealt with the treatment of abuse in individual families. However, with all our efforts focused on individual pathology, we will not solve the causal problem rooted in our social structure. As long as societies continue to oppress women and permit fathers to dominate their families, such men will have the power to use and abuse their children. Therefore, prevention of abuse in the family will ultimately require a radical transformation of the family. Rule by the father will have to yield to the cooperative rule of both parents. Division of labor by sex will have to be altered so that fathers and mothers share equally in the care of their children.

Men are also oppressed by this patriarchal system, which denies them a part of their emotionality. All of the qualities associated with mothering --tenderness, emotional responsiveness, and nurturing -- are suppressed by most men. The result is the formulation of a male psychology where dominance is revered, and the capacity for caretaking is atrophied.

Our children need to grow up with a new and different image of mother and father.

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